EXHIBIT 2

Application for Individual and Multi-Life Life Insurance

Metropolitan Life Insurance Company
One Madison Avenue
New York, NY 10010-3690

New England Life Insurance Company
501 Boylston Street
Boston, MA 02116-3700

General American Life Insurance Company
700 Market Street
St. Louis, MO 63101

MetLife Investors USA Insurance Company
222 Delaware Ave, Suite 900
P.O. Box 25130
Wilmington, DE 19899

MetLife Investors Insurance Company
700 Market Street
St. Louis, MO 63101

BELOW ARE INSURANCE FRAUD WARNING STATEMENTS THAT APPLY TO RESIDENTS OF SPECIFIC STATES. PLEASE READ IF THE STATE IN WHICH THE OWNER RESIDES IS LISTED.

Arkansas, Kentucky, Louisiana, New Mexico, Ohio, Oklahoma, Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of life insurance and civil damages. It is also unlawful for any insurance company or agent of an insurance company to knowingly provide false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with respect to a settlement or award from insurance proceeds. Such acts shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

Washington D.C., Maine, Tennessee, Virginia
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

Florida
Any person who knowingly and with the intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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Part I

Company Use Only (Policy Numbers/Billing/MSA Number)

☑ Metropolitan Life Insurance Company
☐ New England Life Insurance Company ☐ General American Life Insurance Company
☐ MetLife Investors USA Insurance Company ☐ MetLife Investors Insurance Company

The Company indicated above is referred to as "the Company".

1. Proposed Insured #1: Life 1

Name: First, Middle, Last	Sex	DOB Mo./Day/Yr.	State/Country of Birth	Social Security Number
BANG LIN	M	8/6/69	TAIWAN	085-66-4606

a) Current Residence Address and Phone Number:
7 GREEN HOLLOW (Street), IRVINE (City), CA (State) 92620 (Zip)
(714) 734-9029 (Home Phone) (949) 756-2222 (Work Phone) Best time and place to call: after 10 AM ☑ a.m. ☐ p.m. ☐ Home ☑ Work

E-Mail Address:

b) Driver's License Number and State of Issue: A9644172 exp. 8/6/08

c) Employer's Name: Uni Micro

d) Occupation & Duties: President

e) Earned Annual Income: $ 150,000- Net Worth: $ 2,500,000-

f) Are you actively at work? ☑ Yes ☐ No (If No, provide details)

2. Proposed Insured #2: Life 2 or Spouse/Covered Insured/Applicant's Waiver of Premium Benefit (For multiple persons under a Covered Insured rider, complete Other Insureds Supplement for additional persons.)

Name: First, Middle, Last	Sex	DOB Mo./Day/Yr.	State/Country of Birth	Social Security Number	Relationship to Proposed Insured #1

a) Current Residence Address and Phone Number (if different than Proposed Insured #1):

(Street) (City) (State) (Zip)

( ) (Home Phone) ( ) (Work Phone) Best time and place to call: ☐ a.m. ☐ p.m. ☐ Home ☐ Work

E-Mail Address:

b) Driver's License Number and State of Issue:

c) Employer's Name:

d) Occupation & Duties:

e) Earned Annual Income: $ Net Worth: $

f) Are you actively at work? ☐ Yes ☐ No (If No, provide details)

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3. ...isting or applied for insurance, including any term riders or annuities: (If additional space is needed, provide details in the Supplemental Information section. If any existing insurance, complete state replacement forms as necessary.) If no existing or applied for insurance or annuity, check here. ☐ **[Type: Life (L), Disability (D), Health (H), Annuity (A)]**

Proposed Insured	Company	Type (L,D,H,A)	Amount	Year of Issue	Accidental Death Amount	1035
Insured	MetLife	L	500K	99	500,000 -	☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes

4. In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? (If Yes, complete the Replacement Questionnaire and Disclosure and any applicable replacement forms.) ☐ Yes ☑ No

5. Indicate Plan and Face Amount: ☐ **list below or** ☐ **complete Product Supplement.**

a) Type of Insurance: ☑ Individual Life ☐ Survivorship/Joint Life

☐ Group Conversion (For MetLife only.) (Complete Product Supplement.) ☐ Qualified Plan (Employee Group Number _____)

b) Plan: 15 Years Term c) Face Amount: $ 1,000,000 -

Complete for Universal Life/Variable Life Products. (For Variable Life, also complete Variable Life Supplement.)

d) Planned Premium (modal): Year 1: $ _____ Excess/Lump Sum: $ _____

Renewal (If applicable): $ _____ Planned Annual Unscheduled Payment (If applicable): $ _____

e) Definition of Life Insurance Test (If choice is available under policy applied for.):

☐ Guideline Premium Test ☐ Cash Value Accumulation Test

f) Death Benefit Option/Contract Type: _____

g) Guarantee to Age: _____ or ☐ 5 Years (for MetLife Variable only.)

h) **Optional Benefits/Riders/Dividend Option:** ☐ **list below or** ☐ **complete Product Supplement.**

disability waiver	

i) **Special Requests/Other: list below**

$72.-/month

j) Do you request an alternate/additional policy (If available)? ☐ Yes ☐ No
(If Yes, provide full details in Supplemental Information section and include signed and dated illustration for each policy requested.)

6. MODE OF PAYMENT

a) Mode of Payment: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☑ Bank Draft
☐ Special Accounts _____ ☐ Other _____

(Additional details/existing/new account numbers, etc.): _____

b) Amount collected with application $ 72 / must equal at least one monthly premium.

7. SOURCE OF PAYMENT (Check all that apply:)

☐ Earned Income ☐ Money Market Fund ☐ Certificate of Deposit
☐ Rollover/Transfer of Assets ☑ Savings ☐ Loan ☐ Other _____
☐ Mutual Fund/Brokerage Account ☐ Use of values in another Life Insurance/Annuity Contract

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8. What is the purpose of this insurance? (Check all that apply:) ☐ Income Protection ☐ Business Planning
☐ Estate Planning ☑ Mortgage Protection ☐ Retirement Supplement ☐ Education Funding
☐ Final Expenses ☐ Charitable Giving ☐ Other _____

Provide the following information for all Primary/Contingent Owners and Beneficiaries:
name; relationship to Proposed Insured(s); date of birth; social security/tax ID number; and address. Include E-Mail address. If Trust, provide Trustee Name and Date of Trust. Indicate additional: Owners; Contingent Owners; Primary Beneficiaries; and Contingent Beneficiaries in Supplemental Information section.

9. Owner/Contingent Owner Information

a) Identity of Owner: Proposed Insured #1 ☑ #2 ☐

Jean Lin 100%
5/19/71 Spouse
128-64-5329

b) Identity of Contingent Owner (if applicable):

10. Beneficiary Information

Note: Multiple beneficiaries will receive equal proceeds unless otherwise requested by Owner.

a) Identity of Primary Beneficiary: ☐ Owner

Jean Lin
5/19/71 Spouse
128-64-5329

b) Identity of Contingent Beneficiary:

Chelsey Lin 50%
11/3/96
daughter
S.S.#: 626-92-1165

Angus Lin 50%
11/9/95
S.S.#: 604-86-5448
Son

☐ Check here if all present and future natural or adopted children of Proposed Insured #1 are to be included as Contingent Beneficiaries.

11. Billing/Mailing Address:*

☑ Proposed Insured #1 Residence Address:*
☐ Proposed Insured #2 Residence Address
☐ Owner's Address (If not Owner listed in question 9a, indicate name and address below.)
☐ Primary Beneficiary's Address (If not Beneficiary listed in question 10a, indicate name and address below.)
☐ Other Premium Payer (Indicate name and address below.)

(If Other, indicate relationship to Proposed Insured(s).) _____
Relationship

(Name: Address: Street City/ State/ Zip)

*If any other special mailing arrangements are needed, indicate in Supplemental Information section.

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12. Any person to be insured a dependent spouse or dependent minor? (If Yes, provide details below.) ☐ Yes ☒ No

a) Amount of insurance on spouse: Existing: $ _____ Applied For: $ _____

b) If dependent minor, are there any other siblings insured for less than this child? (If Yes, provide details in Supplemental Information section.) ☐ Yes ☒ No

c) Amount of existing and applied for insurance on parents of dependent minor:

	Amount			Amount	
Father's Name	Existing	Applied For	Mother's Name	Existing	Applied For

Part II

13. Within the past three years has any person to be insured flown in a plane other than as a passenger on a scheduled airline or have plans for such activity within the next year? (If Yes, complete Aviation Supplement.) ☐ Yes ☒ No

14. Within the past three years has any person to be insured participated in or intend to participate in any: underwater sports (SCUBA diving, hardhat, skin diving, snorkeling); sky sports (skydiving, hang gliding, parachuting, ballooning); racing sports (motorcycle, auto, motor boat); rock or mountain climbing; bungee jumping or other similar activities? (If Yes, complete Avocation Supplement.) ☐ Yes ☒ No

15. Are all persons to be insured U.S. citizens? (If No, provide details below including: country of citizenship; Visa/ID Card type; number; and expiration date.) ☒ Yes ☐ No

16. Has any person to be insured traveled or resided outside the U.S. or Canada in the past two years OR does any person to be insured intend to travel or reside outside the U.S. or Canada in the next 12 months? (If Yes, provide details below including: country; city; duration; and purpose.) ☐ Yes ☒ No

17. Has any person to be insured ever used tobacco products: (e.g. cigarettes; cigars; pipes; smokeless tobacco; chew) or nicotine substitutes: (e.g. patch or gum)? (If Yes, provide type, amount, date last used, and frequency below.) ☐ Yes ☒ No

18. Has any person to be insured: ever had a driver's license suspended or revoked; ever been convicted of DUI or DWI; or had any moving violations in the last five years? (If Yes, provide details below.) ☐ Yes ☒ No

Give details for question 15 through 18. Attach additional sheet(s), if necessary.

Proposed Insured	Question Number(s)	Date	Details

19. Attending Physician(s) of the Proposed Insured(s): (Provide: name; address; phone number; date; and reason for last consultation. Attach additional sheet(s), if necessary.)

Proposed Insured #1

Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment
Dr. James Hwang 340 W. Central Ave. #119 Brea, CA 92821 714-990-0325	8/04 Regular check up Normal

Proposed Insured #2

Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment

20. Proposed Insured #1 Height: 5'6" Weight: 105	Proposed Insured #2 Height: _____ Weight: _____

21. Has any person proposed for insurance EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had: (Provide details for each Yes answer below.)

a)	High blood pressure; chest pain; heart attack; or any other disease or disorder of the heart or circulatory system?	☐ Yes ☑ No
b)	Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the respiratory system?	☐ Yes ☐ No
c)	Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; Parkinson's; or any other disease or disorder of the brain or nervous system?	☐ Yes ☑ No
d)	Ulcers; colitis; hepatitis; cirrhosis; or any other disease or disorder of the liver, gallbladder, stomach, or intestines?	☐ Yes ☑ No
e)	Any disease or disorder of: the kidney; bladder; or prostate; or protein or blood in the urine?	☐ Yes ☑ No
f)	Diabetes; thyroid disorder; or any other endocrine disorders?	☐ Yes ☑ No
g)	Arthritis; gout; or disorder of the muscles, bones, or joints?	☐ Yes ☐ No
h)	Cancer; tumor; polyp; cyst; anemia; leukemia; or any other disorder of the blood or lymph glands?	☐ Yes ☐ No
i)	Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	☐ Yes ☐ No

22. Has any person proposed for insurance: (Provide details for each Yes answer below.)

a)	In the past six months, taken any medication or been under observation or treatment?	☐ Yes ☑ No
b)	Scheduled any: doctor's visits; medical care; or surgery for the next six months?	☐ Yes ☐ No
c)	During the past five years had any: checkup; health condition; or hospitalization not revealed above?	☐ Yes ☐ No
d)	Ever been diagnosed with, treated by a medical professional for, or tested positive during a medical examination for life insurance for; any of the following: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); AIDS (Human Immunodeficiency Virus (HIV)) virus; or antibodies to the AIDS (HIV) virus?	☐ Yes ☐ No
e)	Ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?	☐ Yes ☑ No
f)	Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?	☐ Yes ☐ No

23. Answer Question 23 only when requesting the Long-Term Care Guaranteed Purchase Option.
(Provide details for each Yes answer below.)

a)	Do you currently use any mechanical equipment i.e.: a walker; wheelchair; leg braces; or crutches?	☐ Yes ☐ No
b)	Do you need any assistance; or supervision with the following activities bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence; or taking medication?	☐ Yes ☐ No

Give details of each Yes answer from Questions 21, 22, and 23. Attach additional sheet(s), if necessary.

Proposed Insured	Question Number	Name/Address of Physician	Date/Duration Illness	Diagnosis/Severity/Treatment

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24. Has a parent or sibling of any person to be insured ever had heart disease, coronary artery disease, high blood pressure, cancer, diabetes or mental illness? (If Yes, complete rest of question 24.) ☐ Yes ☒ No

Relationship to Proposed Insured #1:	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death (Attach additional sheet(s), if necessary.)

Relationship to Proposed Insured #2:	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death (Attach additional sheet(s), if necessary.)

Supplemental Information Section or Special Requests from Agent/Producer. Attach additional sheet(s) if necessary.

Home Office Endorsements: (Not applicable to: FL, KY, MD, MA, MN, MO, OR, PA, PR, WV, WI.)

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AGREEMENT/DISCLOSURE

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- My acceptance of any insurance policy means I agree to any changes shown in the Home Office Endorsements section, where state law permits Home Office endorsements.
- This application and any: amendment(s); paramedical/medical exam; and supplement(s) that become part of the application, will be attached to and become part of the new policy.
- Only the Company's President, Secretary or Vice-President may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- No information will be deemed to have been given to the Company unless it is stated in this application and its supplement(s), paramedical/medical exam, and amendment(s).
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I intend to replace existing insurance or annuities, I have so indicated in question 4 of this application.
- I have received the Company's Consumer Privacy Notice and, as required, the Life Insurance Buyer's Guide.
- If I was required to sign an HIV Informed Consent Authorization, I have received a copy of that Authorization.

Substitute Form W-9 – Request for Taxpayer Identification Number

Under penalties of perjury, I, Jean Lin (Owner's Name) (128-64-5329 (Owner's Taxpayer ID #)) **certify:**

1) **That the number shown above is my correct taxpayer identification number; and**
2) **That I am not subject to backup withholding because: (a) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding; and**
3) **I am a U.S. citizen or a U.S. resident for tax purposes.***

Please note: Cross out and initial item 2 if subject to backup withholding as a result of a failure to report all interest and dividend income. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications to avoid backup withholding.

*If you are not a U.S. citizen or a U.S. resident for tax purposes, please complete form **W-8BEN**.

Signatures:

	Signed at City, State	Mo./Day/Yr.	Signature
Owner* (age 15 or over) (If other than a Proposed Insured)	Irvine, CA	8/5/04	X
Proposed Insured #1 (age 15 or over)	Irvine, CA	8/5/04	X
Proposed Insured #2 (age 15 or over)			X
Parent or Guardian or person liable for child's support			X

(Signature required if Owner or Proposed Insured(s) is/are under the age of 18 and the Parent, Guardian or person liable for the child's support has not signed above.)

Witness to Signatures (Licensed Agent/Producer)	Irvine, CA	8/5/04	X

***If the Owner is a Firm or Corporation, include Officer's Title with signature. (Officer signing must be other than a Proposed Insured.)**

PART II: Paramedical/Medical Exam

Case/Policy No.: 20 4 1 2 6 4 8 6

- [x] Metropolitan Life Insurance Company
- [ ] MetLife Investors Insurance Company of California
- [ ] New England Life Insurance Company
- [ ] Texas Life Insurance Company
- [ ] Metropolitan Tower Life Insurance Company
- [ ] Metropolitan Insurance and Annuity Company
- [ ] MetLife Investors USA Insurance Company
- [ ] General American Life Insurance Company

The Company indicated above is referred to as "the Company".
For Texas Life: If medical examination *is not* required: questions are to be completed by Agent.

The spaces below are for answers of person to be examined only. Nothing but the answers of such person should be recorded.

1. Name of Proposed Insured: (Last, First, Middle) LIN. BANG C — Date of Birth: (Mo./Day/Year) 08-06-1969

2. Tobacco Use – Indicate date last smoked/used:

Cigarette	Smokeless Tobacco	Cigar/Pipe	Patch/Gum
__/__/__ ☒ Never	__/__/__ ☒ Never	__/__/__ ☒ Never	__/__/__ ☒ Never

Amount/Frequency: — Tobacco Never Used: ☒ Yes ☐ No

3. Who is the doctor, practitioner, or health care facility who can give us the most complete and up to date information concerning your present health? If "None", check ☐.

Name, full address, and phone number: Dr. JAMES MUAMET (714) 990-0376
340 WEST Central AVE #119. BREA, CA 92821

When was this doctor last consulted? 08/2004 — Why? SKIN itching

What treatment was given or medication prescribed? If "None", check ☒

Reasons, findings, earlier consultations past 5 years? — WNL

4. a) Height 5 ft. 8 in. b) Weight 170 lbs. c) Change in weight in past 12 months (give reason) Pounds lost 0 Pounds gained 0 Reason ____

5.

Have you EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that you had:		Details: List question number. Give: details; dates; duration; diagnosis; treatment; and doctors' names and addresses.
a) High blood pressure; chest pain, heart attack; or any other disease or disorder of the heart or circulatory system?	☐ Yes ☒ No	
b) Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system?	☐ Yes ☒ No	
c) Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; Lou Gehrig's disease (ALS); memory loss; Parkinson's disease; progressive neurological disorder; headaches; dizziness; or any other disease or disorder of the brain or nervous system?	☐ Yes ☒ No	
d) Ulcers; colitis; hepatitis; cirrhosis; or any other disease or disorder of: the liver, gallbladder; stomach; or intestines?	☐ Yes ☒ No	
e) Any disease or disorder of: the kidney; bladder; prostate; reproductive organs; or breasts; sexually transmitted disease; sugar; albumin; blood or pus in the urine?	☐ Yes ☒ No	
f) Diabetes; thyroid disorder; or any other endocrine disorder?	☐ Yes ☒ No	
g) Arthritis; gout; or disorder of the muscles, bones, or joints?	☐ Yes ☒ No	
h) Cancer; tumor; polyp; or cyst? Any disease or disorder of the skin?	☐ Yes ☒ No	

Details (Continued):

	l) Anemia; leukemia; or any other disorder of the blood or lymph glands?	☐ Yes ☒ No	
	j) Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	☐ Yes ☒ No	
	k) Any disease or disorder of the eyes, ears, nose, or throat?	☐ Yes ☒ No	
6.	Are you now, or within the last six months, under observation or taking medication or treatment? (including over the counter medications, vitamins, herbal supplements, etc.)	☐ Yes ☒ No	
7.	Do you have any doctor's visits, medical care, or surgery scheduled?	☐ Yes ☒ No	
8.	Other than the above, during the past five years have you had any:		
	a) Checkup; electrocardiogram; chest x-ray; or medical test?	☐ Yes ☒ No	
	b) Illness; injury; or health condition not revealed above; or have been recommended to have any: treatment; hospitalization; surgery; medical test; or medication?	☐ Yes ☒ No	
9.	Have you:		
	a) ever been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC)?	☐ Yes ☒ No	
	b) ever tested positive during a medical examination for life insurance for the AIDS (HIV) virus or for antibodies to the AIDS (HIV) virus?	☐ Yes ☒ No	
10.	a) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?	☐ Yes ☒ No	
	b) Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?	☐ Yes ☒ No	

11. Do you exercise? ☒ Yes ☐ No Type: SWIMMING / GOLF How often? 2 times/wk 1-3 hrs

12. Are you now pregnant? ☐ Yes ☒ No If "Yes", estimated date of delivery? _____

13. Has a parent or sibling of any person to be insured ever had: heart disease; coronary artery disease; high blood pressure; cancer; diabetes; or mental illness? (If Yes, indicate below.) ☐ Yes ☒ No

Relationship to Proposed Insured:	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death Attach additional sheet(s) if necessary.

14. a) Do you currently use any mechanical equipment such as a walker, wheelchair, long leg braces or crutches? ☐ Yes ☒ No.

b) Do you need any assistance or supervision with the following activities: bathing, dressing, walking, moving in/out of a chair or bed, toileting, continence or taking medication? ☐ Yes ☒ No

I have read the answers to questions 2-14 before signing. They have been correctly written, as given by me, and are true and complete to the best of my knowledge and belief. There are no exceptions to any such answers other than as written.

Witness to Signature	City and State	Mo./Day/Year	Signature of Proposed Insured (Parent or Guardian if under 18)
[signature]	IRVINE, CA	08/18/04	[signature]

Chan Peggy

Report of Paramedical/Medical Examiner

- **Complete Sections I and III for Paramedical Exam**
- **Complete Sections I, II and III for Physician's Exam**

Section I

1. (a) Date of birth 08-06-69 (b) Sex M ☒ F ☐ (c) If female, was proposed insured menstruating on date of this examination? Yes ☐ No ☐

2. Height (in shoes)	Weight (clothed)	Chest (full inspiration)	Chest (forced expiration)	Abdomen (at umbilicus)
5 ft 8 in.	170 lbs.	Males 38 in.	Males 36 in.	Males 33 in.

Did you measure? Yes ☒ No ☐ Did you weigh? Yes ☒ No ☐

3. Blood Pressure (Record ALL readings – at least two):	Sitting Systolic/Diastolic – 5th phase	If systolic over 140 or diastolic over 90, repeat later in exam
	141/74	120/76 / 130/80

4. Pulse At Rest: Rate (per min.) 76 Irregularities (per min.) 0
5. Is appearance unhealthy or older than stated age? Yes ☐ No ☒
6. Urinalysis: Protein: Positive ☐ Negative ☒ Sugar: Positive ☐ Negative ☒
   Is blood also being sent to lab? Yes ☒ No ☐ ECG done?: Yes ☐ No ☒

0058848785

for analysis re

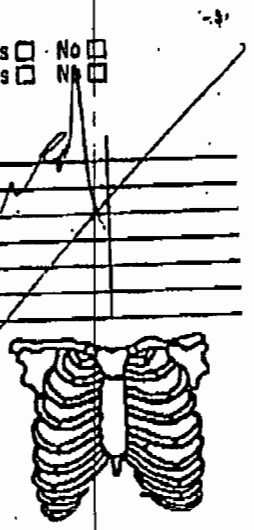
Details for answers to questions 7–11.

Section II

7. Heart: Is there any:
   a) Enlargement? Yes ☐ No ☐ c) Dyspnea? Yes ☐ No ☐
   b) Murmur(s)? Yes ☐ No ☐ d) Edema? Yes ☐ No ☐
   (If Yes, complete below)

	Murmur 1	Murmur 2
Location (Apical, Aortic, Pulmonic, Parasternal)		
Timing (Systolic, Presystolic, Diastolic)		
Quality (Coarse, Blowing, Rumbling, Musical)		
Loudness (Grade 1–6)		
Constant (Yes or No)		
Transmitted (Yes or No)		
After Exercise (Increased, Absent, Unchanged, Decreased)		

Indicate:
Apex by: X
Murmur area by: ☐
Point of greatest intensity by: 0
Transmission by: →



8. Is there on examination any abnormality of the following? ☐ Yes ☐ No
   a) Eyes, ears, nose, mouth pharynx? (If vision or hearing markedly impaired, indicate degree and correction.) ☐ Yes ☐ No
   b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries? ☐ Yes ☐ No
   c) Nervous system (include reflexes, gait, and paralysis)? ☐ Yes ☐ No
   d) Respiratory system? ☐ Yes ☐ No
   e) Abdomen (describe scars, liver enlargement)? ☐ Yes ☐ No
   f) Genitourinary system? ☐ Yes ☐ No
   g) Endocrine system (include thyroid)? ☐ Yes ☐ No
   h) Musculoskeletal system (include spine, joints, amputations, and deformities)? ☐ Yes ☐ No
9. Are there any hernias? ☐ Yes ☐ No
10. Are you aware of additional medical history? ☐ Yes ☐ No
11. Are you the personal physician of the applicant? ☐ Yes ☐ No
12. Please provide your overall clinical impression of proposed insured:

08/18/04

Date/Time of exam 10:00 PM

Section III Name of person examined

Place of exam: ☐ Examiner's office ☐ Proposed Insured's Residence ☒ Proposed Insured's Business

City/State IRVINE, CA

Agent/Broker

Signature of Paramedical/Medical Examiner

Printed Name

APPS #09
9465 Wilshire Blvd. #2220
Los Angeles, CA 90010
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Tax: 112298722

Branch/District # or Agency Name 1886 / 878-1

Tax ID #